EXHIBIT B

The Estee Lauder Companies Inc.

OPEN ACCESS PLUS MEDICAL BENEFITS

THE CUSTOM CARE MEDICAL PLAN

THE COMPREHENSIVE PLUS MEDICAL PLAN

EFFECTIVE DATE: January 1, 2010

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This document printed in February, 2012 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Important information

This is not an insured benefit plan. The benefits described in this booklet or any rider attached hereto are self-insured by The Estee Lauder Companies Inc. which is responsible for their payment. Connecticut General provides claim administration services to the plan, but Connecticut General does not insure the benefits described.

This document may use words that describe a plan insured by Connecticut General. Because the plan is not insured by Connecticut General, all references to insurance shall be read to indicate that the plan is self-insured. For example, references to "CG," "insurance company," and "policyholder" shall be deemed to mean your "employer" and "policy" to mean "plan" and "insured" to mean "covered" and "insurance" shall be deemed to mean "coverage."

This Summary Plan Description booklet describes the benefits provided by The Custom Care Medical Plan and The Comprehensive Plus Medical Plan as of January 1, 2009. These Plans are part of The Estée Lauder Companies Health Care Program. This booklet is designed to meet disclosure requirements under the Employee Retirement Income Security Act of 1974 (ERISA). In addition to The Custom Care and Comprehensive Plus Medical Plans, the Health Care Program includes The Medical Plan, the Prescription Drug Plan and the Dental Assistance Plan, all of which are described in separate booklets or brochures. Complete details of the Health Care Program are included in the legal documents that govern the operation of the Plans which make up the Program. If there is a difference between this booklet and the legal documents, the documents always prevail.

This booklet has been prepared for employees of The Estée Lauder Companies and any subsidiary and affiliate to which the Program is extended. A list of participating employers appears on page 55.

The Estee Lauder Inc. Employee Benefits Committee has the authority to amend or terminate any Plans in the Benefit Program at any time, for any reason, subject to the provisions of applicable law. In addition, nothing in this booklet implies a contract of employment or confers any right to be retained in the employ of the Company.

Table of Contents

CIGNA HealthCare

Special Plan Provisions

When you use an Open Access Plus (OAP) network Participating Provider, this Plan pays a greater share of the costs than if you select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. For a list of Participating Providers in your area, consult your Physician Guide, visit our website, at http://provider.healthcare.cigna.com/EsteeLauder.html, or call the toll-free number shown on the back of your Plan ID card. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

Services Available in Conjunction With Your Medical Plan

The following sections describe helpful services available in conjunction with your medical Plan. You can access these services by calling the toll-free number shown on the back of your ID card.

CIGNA'S Toll-Free Care Line

CIGNA's toll-free Care Line allows you to talk to a health care professional from 8 a.m. to 6 p.m., Monday through Friday, simply by calling the toll-free number shown on your ID Card.

CIGNA's toll-free Care Line personnel can provide you with the names of Participating Providers. If you or your Dependents need medical care, you may consult your Physician Guide, which lists the Participating Providers in your area, or call CIGNA's toll-free number for assistance. If you or your Dependents need medical care while away from home, you may have access to a national network of Participating Providers through CIGNA's Away-From-Home Care feature. Call CIGNA's toll-free Care Line for the names of Participating Providers in other network areas. Whether you obtain the name of a Participating Provider from your Physician Guide or through the Care Line, it is recommended that prior to making an appointment you call the provider to confirm that he or she is a current participant in the Open Access Plus (OAP) network.

Case Management

Case Management is a service provided through a Review Organization, Intracorp, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Intracorp Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your Dependent. In addition, Case Managers are supported by a panel of physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending physician remains responsible for the actual medical care.

1. You, your Dependent or an attending physician can request Case Management services by calling the toll-free number shown on your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program [see the Pre-Admission Certification (PAC)/Continued Stay Review (CSR) section of this booklet] may refer an individual for Case Management.
2. The Review Organization assesses each case to determine if Case Management is appropriate.
3. You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.
4. Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
5. The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
6. The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).

7. Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

Well Aware Program for Better Health

The Well Aware Program is a confidential, voluntary health improvement program for people with certain chronic health conditions like diabetes, heart disease, obesity, low back pain, etc. It is available to you and your Dependents at no cost. Such conditions can be difficult to manage. The accompanying daily challenges can affect everything you do. Working through these challenges is important for better health and a better quality of life.

When you participate in the Well Aware Program, a professional health team will work with you to create a self-care plan that supports your doctor's plan. It can help you avoid triggers, anticipate symptoms, reduce your risk of complications and improve your health. By teaming up with your doctor, Well Aware makes it easier for you to manage your chronic condition, so that you can spend more time living your life.

Additional Programs

From time to time, CIGNA (CG) may offer or arrange for various entities to offer discounts, benefits, or other consideration to participants (i.e., Employees/Dependents) for the purpose of promoting their general health and well being. Contact CG for details of these programs.

Important Information About Your Medical Plan

Details of your medical benefits are described throughout the remainder of this booklet.

Opportunity to Select a Primary Care Physician (PCP)

Choice of Primary Care Physician:

When you elect to participate in The Health Care Program you may select a Primary Care Physician for yourself and your Dependents from a list provided by CG. If you choose to select a Primary Care Physician, you may designate a different Primary Care Physician for yourself and for each of your Dependents.

Primary Care Physician's Role/Direct Access to Participating Physicians:

The Primary Care Physician's role is to provide or arrange for medical care for you and your Dependents.

However, you and your Dependents are allowed direct access to Participating Physicians for covered services. Even if you select a Primary Care Physician, there is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the Participating Physician of your choice, including Participating Specialist Physicians, for covered services.

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another by contacting us at the member services number shown on your ID card, or by visiting our website at http://provider.healthcare.cigna.com/ EsteeLauder.html. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician, if you choose.

How To File Your Claim

If you receive medical care from an Open Access Plus network provider, you don't need to file a claim for expenses – these claims are handled by the provider.

To receive Out-of-Network benefits, you will need to apply for them. The prompt filing of any required claim form will result in faster payment of your claim.

You may obtain the required claim forms from your Benefit Plan Administrator. All fully completed claim forms with itemized bills should be sent directly to the CG Claim Office address which appears on your ID card).

In accordance with your Plan benefits, file your claim forms as described below.

Hospital Expenses

If you or your Dependent is admitted to a hospital or treated in an emergency room, present your ID card to the admitting office at the time of your admission. This will make your admission easier and any cash deposit usually required will be waived. The hospital will submit your bill directly to CG. (Note: your OAP network provider will arrange for your

admission and complete the procedure described in the Pre-Admission Certification/Continued Stay Review section. If you use an Out-of-Network provider, you will be responsible for doing this.

Doctor's Bills and Other Medical Expenses

If you use a Participating Provider, your claim will automatically be submitted to CG by your provider. Whenever you or a covered Dependent has incurred covered Out-of-Network medical expenses, submit a completed claim form to CG, along with itemized copies of your bills.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT NUMBERS WHEN YOU FILE CG'S CLAIM FORMS OR WHEN YOU CALL YOUR CG CLAIM OFFICE.

  YOUR MEMBER ID IS THE ID NUMBER SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

  YOUR ACCOUNT NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS (YOUR CLAIM MUST BE RECEIVED BY CG WITHIN 12 MONTHS FROM DATE OF SERVICE TO BE CONSIDERED FOR REIMBURSEMENT).

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

Eligibility – Effective Date

Eligibility for Employee Coverage

You will become eligible to participate in The Health Care Program on the day you complete the waiting period (see below) if you are a regular, full-time Employee of The Estee Lauder Companies Inc.

Full-time means you are regularly scheduled for and working at least 30 hours a week. (If you are part-time or temporary, you are not eligible.)

Eligibility for Dependent Coverage

You will become eligible to elect Dependent coverage on the later of:

- the day you first become eligible for coverage or
- the day you acquire your first Dependent.

Waiting Period

For regular, full-time Employees (who are not considered to be "In-Store" Employees), the first day of the month coincident with or next following date of hire (or benefits eligibility date, if later).

For regular, full-time In-Store Employees, the first day of the month coincident with or next following completion of 3 months of full-time employment (or benefits eligibility date, if later). In accordance with Company policy, newly eligible In-Store Employees may receive credit towards the waiting period for certain periods of prior service.

Cost of Coverage

You and your Employer share the cost of coverage for you and your eligible Dependents. Your Employer pays most of the cost and, except for Domestic Partner benefits, you pay the balance on a pre-tax basis through your paycheck. Under current tax regulations, this means that your contributions will not be subject to federal, F.I.C.A. (i.e., Social Security) and, in most cases, state or city taxes.

Your contributions for Domestic Partner coverage must be made on an after-tax basis. Additionally, the value of the employer-paid benefits for your Domestic Partner is taxable to you.

Enrollment

To enroll, you must complete a Health Care Program Enrollment Form and return it to your local Human Resources representative within 30 days following your date of hire (or benefits eligibility date, if later). On the form, you need to:

- Decide which medical coverage you want. You may choose from The Custom Care Medical Plan or The Comprehensive Plus Medical Plan.
- Decide who you wish to cover. You can select coverage for yourself only (individual coverage) or for you and your eligible Dependents (family coverage).
- Authorize your Employer to make payroll deductions for the coverage you choose.

Your coverage election will remain in effect for the entire calendar year, as long as you remain eligible. It may not be changed during the year, unless you experience one of the "Special Enrollment Events" described on page 44.

However, you may change or cancel your coverage on any January 1st without restriction (except in the case of cancellation, as described in the next paragraph). If you do not make any coverage change, your prior year's election will remain in effect.

If you are a regular, full-time Employee and want to waive Health Care Program coverage but cannot demonstrate that

you are covered by another health plan, or if you do not return your enrollment form within 30 days of the date you initially become eligible, you will *automatically be enrolled for individual coverage* under The Custom Care Medical Plan. If so, applicable deductions will be taken from your pay.

If you are an In-Store Employee and do not wish to enroll in The Health Care Program, you must complete the "Coverage Waiver" section of the Health Care Program Enrollment Form (i.e. Section III).

Regardless of whether or not you elect to participate in The Health Care Program, you must sign the Enrollment Form and complete a Dependent Data Form.

Delayed Enrollment

If you and/or your Dependents choose to delay enrollment in The Health Care Program beyond 30 days after your initial eligibility date, you or they may enroll at a future date. There are two types of delayed enrollment:

Timely Enrollment - If the following conditions are met, and application for coverage is made within 30 days of a "triggering event" (as defined below), you and/or your eligible Dependents may enroll without any coverage restriction:

- You or your eligible Dependent must have been covered by another group health plan or other health insurance at the time you or they became eligible for coverage under The Health Care Program.
- You must have stated in writing, within 30 days of your or your Dependent's initial eligibility date that the reason you and/or they declined Health Care Program coverage was that such other coverage was in effect. (Completion of Section III. of The Health Care Program Enrollment Form will satisfy this requirement.)
- Your and/or your Dependent's coverage under the other health care plan must have been terminated because of a change in status, i.e., a "triggering event." Such events include loss of eligibility for coverage due to legal separation, divorce, death, termination of employment or reduction in number of hours of employment, termination of an employer's contributions toward the cost of coverage or exhaustion of COBRA coverage.

In addition, if you acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption, or if your Domestic Partner meets the requirements for plan participation, you and your Dependents may enroll, without coverage restriction, provided that you request enrollment within 30 days after any of these events occurs.

Late Enrollment - If you and/or your Dependents do not satisfy all of the requirements listed in the preceding section and wish to enroll in The Health Care Program after first eligible to do so, you and/or they will be considered a "Late Enrollee":

- This means that coverage of any "pre-existing" medical condition that you and/or your Dependents may have will be restricted for the first 18 months of Health Care Program participation.
- During this 18 month period, no reimbursement will be made under The Health Care Program for any expenses related to such pre-existing condition.
- A *pre-existing condition* is any medical condition (whether physical or mental, regardless of cause) for which treatment has been received within the 6 month period immediately preceding the effective date of your Health Care Program coverage. For this purpose, treatment includes receipt of medical advice, diagnosis, care or the recommendation of treatment.
- The 18 month pre-existing condition exclusion period will be reduced by the number of days, if any, during which you and/or your Dependents were continuously covered under another group health plan or other health insurance (i.e., had "creditable" coverage), prior to enrollment in The Health Care Program. However, if this other coverage was not in effect during the 63 day period immediately preceding your Health Care Program enrollment date, it will not be counted towards reducing the pre-existing condition exclusion period.
- As a Late Enrollee, you and/or your Dependents must wait until a January 1st to enroll in The Health Care Program (except in the case of a "triggering event"). Additionally, coverage under the Dental Assistance Plan will not begin until 1 year from the date of enrollment in The Health Care Program.

Effective Date of Coverage

If you elect to enroll in The Health Care Program, you and your eligible Dependents will become covered upon completion of the applicable Waiting Period, if you are in Active Service at that time (or, if not in Active Service due to your health status). Your Dependents may be covered only if you have elected coverage.

As noted in the preceding "Delayed Enrollment" section, if you and/or your Dependents choose not to enroll when first eligible to do so, you and/or they may enroll at a future date. In this case, coverage will become effective on the first day of the month which falls on or next follows receipt of your enrollment form by your local Human Resources representative.

CIGNA HealthCare

Adding Dependents Later On and Changing Your Election

Adding family members after you are enrolled works like this:

- If you are enrolled for individual coverage and wish to change to family coverage because you acquire a new Dependent, you must make a new coverage election and add your new Dependent.
- To do so, you must complete a new enrollment form and submit it to your local Human Resources representative within the 30 day period following the date your new Dependent became eligible to participate in The Health Care Program.
- Coverage for your new Dependent will begin on the first day of the month which falls on or next follows his or her eligibility date.
- If you do not enroll a new Dependent within 30 days of the date he or she first becomes eligible for coverage, you may apply for coverage later on. However, certain restrictions may apply as described in the "Delayed Enrollment" section.

In addition to being permitted to modify your coverage in the event you acquire a new Dependent through marriage or birth or adoption of a child, you may also change or cancel coverage at any time during the year if you experience any of the other Changes in Status described in the "Effects of Section 125 Regulations on this Plan" section.

If you wish to cancel coverage during the year, you may as long as your reason for doing so is consistent with the change in your family status. For example, if you get married and will be added to your new spouse's coverage through his or her employer, you may drop your Health Care Program coverage. On the other hand, if you are currently enrolled for family coverage and have a new child, you may not cancel your family coverage or change to single coverage. Also, you may not switch in mid-year from one Company-sponsored medical plan to another (e.g., from The Custom Care Medical Plan to The Comprehensive Plus Medical Plan) because of a change in family status.

Additionally, you may terminate the coverage for your Domestic Partner at any time without the need to obtain the consent of your non-employee partner.

Exception for Newborns

Any Dependent child born while you are a participant in The Health Care Program will automatically become covered from birth for a period of 30 days.

If you are enrolled for Individual coverage at that time, to continue your newborn's coverage beyond 30 days, you must enroll for Dependent benefits by completing a Health Care Program Enrollment Form and returning it to your local Human Resources representative no later than 30 days after his/her birth. If you do not enroll your newborn within 30 days of birth, coverage for that child will end on the 30th day. No benefits for expenses incurred beyond the 30th day will be payable.

If you are enrolled for Dependent coverage when your child is born, and you do not contact Human Resources within 30 days of birth to add your newborn to your coverage, claim payments will be suspended until you have done so.

CIGNA HealthCare

THE CUSTOM CARE MEDICAL PLAN
And
THE COMPREHENSIVE PLUS MEDICAL PLAN

(OPEN ACCESS PLUS MEDICAL BENEFITS)

The Benefit Schedule

This schedule includes key provisions of your medical benefits. It should be used together with the full plan details that follow this section beginning on page 30.

For You and Your Dependents
Your medical benefits provide coverage for care both In-Network (from Participating Providers) and Out-of-Network (from Non-Participating Providers). To receive medical benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Coinsurance or Deductible.

Copayments
Copayment is the charge you or your Dependent is required to pay to a Participating Provider at the time services are received.

Coinsurance
The term Coinsurance means the percentage of charges for Covered Expenses that you and/or the Company are required to pay under the Plan for services received from a Non-Participating Provider.

Deductibles

Deductibles are also charges to be paid by you or your Dependents for services received from Non-Participating Providers. Deductible amounts are separate from and in addition to any Copayments or Coinsurance you may be required to pay. Once the Individual or Family Calendar Year Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical deductibles for the rest of that year.

Maximum Reimbursable Charge
In-Network services are covered by the Plan based on the fee agreed upon between CG and the provider. Out-of-Network services are paid based on the Maximum Reimbursable Charge. For this Plan, the Maximum Reimbursable Charge is calculated at the 90th percentile of all charges made by providers of such service or supply within the same geographic area.

CIGNA HealthCare

Out-of -Pocket Expenses
Out-of-Pocket Expenses are Covered Expenses incurred for Out-of-Network charges that are not reimbursed by the medical plan because of any applicable Coinsurance. When the Out-of-Pocket Maximum shown in The Schedule is reached, medical plan benefits will be payable at 100%. However, the following incurred charges will not accumulate toward the Out-of-Pocket Maximum for Covered Expenses, nor will they be reimbursed at 100% even if this maximum has been reached:

- any expenses applied to satisfying the Plan Deductible;
- non-compliance penalties;
- provider charges in excess of the Maximum Reimbursable Charge;
- Out-of-Network Preventive Care;
- Out-of-Network fertility drugs;. or
- Chiropractic Care

Accumulation of Plan Deductibles, Out-of-Pocket Maximums and Other Plan or Service-Specific Maximums
Deductibles, Out-of-Pocket Maximums and other Plan or service specific maximums will cross accumulate between In- and Out-of-Network and all medical plans, unless otherwise noted.

Multiple Surgical Reduction
Multiple surgeries performed during one operating session result in payment reduction of 50% on the lower cost procedure. The most expensive procedure is paid as any other surgery (i.e. as if performed by itself).

Assistant Surgeon and Co-Surgeon Charges
The maximum reimbursable amount for an assistant surgeon's or co-surgeon's charges will be 20% of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

CIGNA HealthCare

BENEFIT HIGHLIGHTS	CUSTOM CARE MEDICAL PLAN IN-NETWORK	COMPREHENSIVE PLUS MEDICAL PLAN IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	$2,000,000 per person		
Coinsurance Levels (Amount the plan pays)	100%	80%	70% of the Maximum Reimbursable Charge
Calendar Year Deductible			
Individual	Not applicable	$250 per person	$250 per person
Family	Not applicable	$500 per family	$500 per family
Application of Deductible: If you or any covered Dependent meets the Individual Deductible, no further Deductible will be applied to that person's claims for the rest of the year and eligible expenses will be reimbursed at the Plan's coinsurance. Once the Family Deductible has been met, the entire family's claims for the rest of the year will be reimbursed at the Plan's coinsurance (i.e. no further Deductibles will be applied).			
Annual Out-of-Pocket Maximum			
Individual	$2,500 per person	$2,500 per person	$2,500 per person
Family	$5,000 per person *	$5,000 per person *	$5,000 per person *
Application of Out-of-Pocket Maximum: If you or any family member meets the Individual Annual Out-of-Pocket Maximum, that person's Out-of-Network claims for the rest of the year will be paid at 100%. Once the Family Annual Out-of-Pocket Maximum has been met, the entire family's Out-of-Network claims for the rest of the year will be paid at 100% (i.e. no additional Individual Out-of-Pocket Maximums will apply).	* Combined with Out-of-Network	* Combined with Out-of-Network	* Combined with In-Network

CIGNA HealthCare

BENEFIT HIGHLIGHTS	CUSTOM CARE MEDICAL PLAN IN-NETWORK	COMPREHENSIVE PLUS MEDICAL PLAN IN-NETWORK	OUT-OF-NETWORK
Physician's Services			
Primary Care Physician's Office visit	$20 PCP per office visit copay, then no charge	80% after plan deductible	70% after plan deductible
Specialty Care Physician's Office Visits Consultant and Referral Physician's Services	$30 Specialist per office visit copay, then no charge	80% after plan deductible	70% after plan deductible
Surgery Performed In the Physician's Office	No charge	80% after plan deductible	70% after plan deductible
Second Opinion Consultations (not mandatory)	No charge	100% no deductible	100% no deductible
Allergy Treatment/Injections	$20 PCP or $30 Specialist per office visit copay, then no charge (no charge for allergy injection only)	80% after plan deductible	70% after plan deductible
Allergy Serum (dispensed by the physician in the office)	No charge	80% after plan deductible	70% after plan deductible
Preventive Care			
Routine Preventive Care (includes regular physical exams, immunizations and periodic, age-appropriate screenings such as cholesterol, colon cancer, diabetes, hearing, mammograms, PAP tests, etc.) In Network Calendar Year Maximum: Unlimited Out-of-Network Calendar Year Maximum: $500			
Physician's Office Visit	$20 PCP or $30 Specialist per office visit copay, then no charge	80% after plan deductible	70% after plan deductible
Immunizations	No charge	80% after plan deductible	70% after plan deductible

CIGNA HealthCare

BENEFIT HIGHLIGHTS	CUSTOM CARE MEDICAL PLAN IN-NETWORK	COMPREHENSIVE PLUS MEDICAL PLAN IN-NETWORK	OUT-OF-NETWORK
Mammograms, PSA, Pap Smears Note: covers charges made for a mammogram for women ages 40 and over, every calendar year, or at any age for women at risk, when recommended by a Physician.	No charge	80% after plan deductible if billed by an independent diagnostic facility or outpatient hospital	70% after plan deductible
Inpatient Hospital - Facility Services	90% (subject to the following limits)	80% after plan deductible (subject to the following limits)	70% after plan deductible (subject to the following limits)
Semi-Private Room and Board	Up to the semi-private room negotiated rate	Up to the semi-private room negotiated rate	Up to the semi-private room rate
Private Room	Up to the semi-private room negotiated rate	Up to the semi-private room negotiated rate	Up to the semi-private room rate
Special Care Units (ICU/CCU)	Up to the negotiated rate	Up to the semi-private room negotiated rate	Up to the ICU/CCU daily room rate
Outpatient Facilities Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room.	90%	80% after plan deductible	70% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	90%	80% after plan deductible	70% after plan deductible
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist Other Provider	90%	80% after plan deductible	70% after plan deductible
Assistant Surgeon/Co-surgeon		Maximum of 20% of surgeon's fee	Maximum of 20% of surgeon's fee
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist Other Provider	90%	80% after plan deductible	70% after plan deductible

CIGNA HealthCare

BENEFIT HIGHLIGHTS	CUSTOM CARE MEDICAL PLAN IN-NETWORK	COMPREHENSIVE PLUS MEDICAL PLAN IN-NETWORK	OUT-OF-NETWORK
Emergency and Urgent Care Services			
Physician's Office Visit	$20 PCP or $30 Specialist per office visit copay, then no charge	80% after plan deductible	70% after plan deductible
Hospital Emergency Room	No charge after $50 per visit copay*	No charge after $50 per visit copay*	No charge after $50 per visit copay*
Outpatient Professional services (radiology, pathology and ER Physician)	No charge	80% after plan deductible	70% after plan deductible
Urgent Care Facility or Outpatient Facility	No charge after $30 per visit copay*	No charge after $30 per visit copay*	No charge after $30 per visit copay*
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	No charge	100% no deductible	100% no deductible
Independent x-ray and/or Lab Facility in conjunction with an ER visit	No charge	80% after plan deductible	70% after plan deductible
Ambulance	No charge *copay waived if admitted	100% no deductible	100% no deductible
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities *Note: Custodial Care is Not Covered Calendar Year Maximum: 120 days (combined In- and Out-of-Network, all plans)	No charge	100% after plan deductible	70% after plan deductible

CIGNA HealthCare

BENEFIT HIGHLIGHTS	CUSTOM CARE MEDICAL PLAN IN-NETWORK	COMPREHENSIVE PLUS MEDICAL PLAN IN-NETWORK	OUT-OF-NETWORK
Pre-admission Testing			
Outpatient Hospital Facility	No charge (copays shown below for Advanced Radiological Imaging will apply)	100% after plan deductible	70% after plan deductible
Independent X-ray and/or Lab Facility	No charge (copays shown below for Advanced Radiological Imaging will apply)	100% after plan deductible	70% after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)			
Inpatient Facility	90%	80% after plan deductible	70% after plan deductible
Outpatient Facility	$50 copay, then no charge	80% after plan deductible	70% after plan deductible
Physician's Office	$50 copay, then no charge	80% after plan deductible	70% after plan deductible
Laboratory and Radiology Services			
Physician's Office Visit	$20 copay in addition to PCP or Specialist per office visit copay	80% after plan deductible	70% after plan deductible
Outpatient Hospital Facility	90%	80% after plan deductible	70% after plan deductible
Independent X-ray and/or Lab Facility	No charge after $20 copay	80% after plan deductible	70% after plan deductible

CIGNA HealthCare

BENEFIT HIGHLIGHTS	CUSTOM CARE MEDICAL PLAN IN-NETWORK	COMPREHENSIVE PLUS MEDICAL PLAN IN-NETWORK	OUT-OF-NETWORK
Outpatient Short-Term Rehabilitative Therapy Calendar Year Maximum: Unlimited days Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy	$30 Specialist per office visit copay, then no charge	80% after plan deductible	70% after plan deductible
Chiropractic Care Physician's Office Visit	$30 Specialist per office visit copay, then no charge	80% after plan deductible	70% after plan deductible
Home Health Care Calendar Year Maximum: Unlimited Daily Maximum: 16 hours per day	No charge	80% after plan deductible	70% after plan deductible
Hospice			
Inpatient Services	No charge	100% after plan deductible	70% after plan deductible
Outpatient Services	No charge	100% after plan deductible	70% after plan deductible
Bereavement Counseling			
Services provided as part of Hospice Care			
Inpatient	No charge	100% after plan deductible	70% after plan deductible
Outpatient	No charge	100% after plan deductible	70% after plan deductible
Services provided by Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit	Covered under Mental Health benefit

CIGNA HealthCare

BENEFIT HIGHLIGHTS	CUSTOM CARE MEDICAL PLAN IN-NETWORK	COMPREHENSIVE PLUS MEDICAL PLAN IN-NETWORK	OUT-OF-NETWORK
Maternity Care Services			
Initial Visit to Confirm Pregnancy	$20 PCP or $30 Specialist per office visit copay, then no charge	80% after plan deductible	70% after plan deductible
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	No charge	80% after plan deductible	70% after plan deductible
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	$20 PCP or $30 Specialist per office visit copay, then no charge	80% after plan deductible	70% after plan deductible
Delivery - Facility (Inpatient Hospital, Birthing Center)	90%	80% after plan deductible	70% after plan deductible
Abortion Includes elective and non-elective procedures			
Physician's Office Visit	$20 PCP or $30 Specialist per office visit copay, then no charge	80% after plan deductible	70% after plan deductible
Inpatient Facility	90%	80% after plan deductible	70% after plan deductible
Outpatient Facility	90%	80% after plan deductible	70% after plan deductible
Physician's Services	90%	80% after plan deductible	70% after plan deductible

CIGNA HealthCare

BENEFIT HIGHLIGHTS	CUSTOM CARE MEDICAL PLAN IN-NETWORK	COMPREHENSIVE PLUS MEDICAL PLAN IN-NETWORK	OUT-OF-NETWORK
Family Planning Services			
Office Visits, Lab and Radiology Tests and Counseling	$20 PCP or $30 Specialist per office visit copay, then no charge	80% after plan deductible	70% after plan deductible
Note: The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office.			
Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (includes reversals)			
Inpatient Facility	90%	80% after plan deductible	70% after plan deductible
Outpatient Facility	90%	80% after plan deductible	70% after plan deductible
Physician's Services	90%	80% after plan deductible	70% after plan deductible
Physician's Office	No charge	80% after plan deductible	70% after plan deductible

CIGNA HealthCare

BENEFIT HIGHLIGHTS	CUSTOM CARE MEDICAL PLAN IN-NETWORK	COMPREHENSIVE PLUS MEDICAL PLAN IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial Insemination, In-vitro, GIFT, ZIFT, etc.			
Physician's Office Visit (Lab and Radiology Tests, Counseling)	$20 PCP or $30 Specialist per office visit copay, then no charge	80% after plan deductible	70% after plan deductible
Inpatient Facility	90%	80% after plan deductible	70% after plan deductible
Outpatient Facility	90%	80% after plan deductible	70% after plan deductible
Physician's Services	90%	80% after plan deductible	70% after plan deductible
Infertility Drugs	100% reimbursement if obtained from Caremark Specialty Pharmacy	100% reimbursement if obtained from Caremark Specialty Pharmacy	70% after plan deductible
Lifetime Maximum per member (In- and Out-of-Network and all plans combined. Includes medical and drug expenses.) Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).	$30,000	$30,000	$30,000

CIGNA HealthCare

BENEFIT HIGHLIGHTS	CUSTOM CARE MEDICAL PLAN IN-NETWORK	COMPREHENSIVE PLUS MEDICAL PLAN IN-NETWORK	OUT-OF-NETWORK
Organ Transplants Includes all medically appropriate, non-experimental transplants			
Office Visit	$20 PCP or $30 Specialist per office visit copay, then no charge	80% after plan deductible	70% after plan deductible
Inpatient Facility	100% at LIFESOURCE center (considered Out-of-Network if not LIFESOURCE)	100% after plan deductible at LIFESOURCE center (considered Out-of-Network if not LIFESOURCE)	70% after plan deductible
Physician's Services	No charge at LIFESOURCE center (considered Out-of-Network if not LIFESOURCE)	100% after plan deducitble at LIFESOURCE center (considered Out-of-Network if not LIFESOURCE)	70% after plan deductible
Lifetime Travel Maximum: $10,000 per transplant	No charge (only available when using LIFESOURCE facility)	100% (only available when using LIFESOURCE facility)	Not covered
Durable Medical Equipment Calendar Year Maximum: Unlimited	No charge	80% after plan deductible	70% after plan deductible
External Prosthetic Appliances Calendar Year Maximum: Unlimited	No charge	80% after plan deductible	70% after plan deductible

CIGNA HealthCare

BENEFIT HIGHLIGHTS	CUSTOM CARE MEDICAL PLAN IN-NETWORK	COMPREHENSIVE PLUS MEDICAL PLAN IN-NETWORK	OUT-OF-NETWORK
Nutritional Evaluation Charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease. Calendar Year Maximum: 3 visits per person			
Physician's Office Visit	$20 PCP or $30 Specialist per office visit copay, then no charge	80% after plan deductible	70% after plan deductible
Inpatient Facility	90%	80% after plan deductible	70% after plan deductible
Outpatient Facility	90%	80% after plan deductible	70% after plan deductible
Physician's Services	90%	80% after plan deductible	70% after plan deductible
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.			
Physician's Office Visit	$20 PCP or $30 Specialist per office visit copay, then no charge	80% after plan deductible	70% after plan deductible
Inpatient Facility	90%	80% after plan deductible	70% after plan deductible
Outpatient Facility	90%	80% after plan deductible	70% after plan deductible
Physician's Services	90%	80% after plan deductible	70% after plan deductible

CIGNA HealthCare

BENEFIT HIGHLIGHTS	CUSTOM CARE MEDICAL PLAN IN-NETWORK	COMPREHENSIVE PLUS MEDICAL PLAN IN-NETWORK	OUT-OF-NETWORK
Bariatric Surgery **Note:** Subject to any limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" section of this booklet. Covered surgical procedures: Gastric Bypass w/anastomosis Small Intestine Gastric Stapling Gastroplasty Vertical & Horizontal banded gastroplasty Billiopancreatic diversion Limited to one surgical procedure for weight loss per Lifetime			
Physician's Office Visit	$20 PCP or $30 Specialist per office visit copay, then no charge	80% after plan deductible	70% after plan deductible
Inpatient Facility	90%	80% after plan deductible	70% after plan deductible
Outpatient Facility	90%	80% after plan deductible	70% after plan deductible
Physician's Services	90%	80% after plan deductible	70% after plan deductible
Abdominoplasty/Panniculectomy (limited to medically necessary procedures)	90%	80% after plan deductible	70% after plan deductible
Acupuncture (excluding Acupressure) – must be performed by a Licensed Practitioner. Certain coverage restrictions apply as described under "Covered Expenses."	$30 Specialist per office visit copay, then no charge	80% after plan deductible	70% after plan deductible
Chemotherapy	No charge	100% after plan deductible	70% after plan deductible

CIGNA HealthCare

BENEFIT HIGHLIGHTS	CUSTOM CARE MEDICAL PLAN IN-NETWORK	COMPREHENSIVE PLUS MEDICAL PLAN IN-NETWORK	OUT-OF-NETWORK
Dialysis	No charge	100% after plan deductible	70% after plan deductible
Wigs Limited to 1 wig per occurrence with a $1,500 maximum/$3,000 Lifetime maximum	No charge	80% after plan deductible	70% after plan deductible
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.
Treatment for TMJ (Surgical and Non-Surgical)	Not Covered	Not Covered	Not Covered
Treatment Resulting From Life Threatening Emergencies Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized and will not count toward any plan limits that are shown in the Schedule for mental health and substance abuse services including in-hospital services. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.			
Mental Health			
Inpatient	90%	80% after plan deductible	70% after plan deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)	$30 Specialist per office visit copay, then no charge	80% after plan deductible	70% after plan deductible
Substance Abuse			
Inpatient	90%	80% after plan deductible	70% after plan deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)	$30 Specialist per office visit copay, then no charge	80% after plan deductible	70% after plan deductible

CIGNA HealthCare

Open Access Plus Medical Benefits For You and Your Dependents

Certification Requirements - Out-of-Network

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent requires treatment in a Hospital:

- as a registered bed patient;
- for a Partial Hospitalization for the treatment of Mental Health or Substance Abuse;
- for Mental Health or Substance Abuse Residential Treatment Services.

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital, as described above. In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. For admissions due to pregnancy that are expected to exceed the guidelines described in the "Coverage for Maternity Hospital Stay " section of this booklet, CSR should be requested before the end of the allowable length of stay for continued Hospital Confinement. To obtain information about CG's **Healthy Babies Program**, please contact CG by the end of the third month of pregnancy.

Covered Expenses incurred will not include the first $500 of Hospital charges made for each separate admission to the Hospital unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, within 48 hours after the date of admission. Hospital charges for Bed and Board which are made for any day in excess of the number of days certified through PAC or CSR will be reduced by 50%. Any hospital charges for which PAC/CSR was requested, but which was not certified as Medically Necessary (i.e. the hospital stay was not approved), will be denied.

PAC and CSR are performed through a utilization review program by a Review Organization with which CG has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this Plan, except for the "Coordination of Benefits" section.

Prior Authorization/Pre-Authorized – In-Network

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services;
- inpatient services at any participating Other Health Care Facility;
- residential treatment;
- non-emergency ambulance;
- transplant services: or
- Bariatric surgery.

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after becoming a Plan participant. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by CG. **Benefits for Covered Expenses, and any applicable Copayments, Deductibles or limits, are shown in The Schedule.**

General

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a sub-acute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.

- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
- charges made for a mammogram for women ages 35 to 69, every one to two years, or at any age for women at risk, when recommended by a Physician.
- charges made for an annual Papanicolaou laboratory screening test.
- charges made for an annual prostate-specific antigen test (PSA).
- charges for appropriate counseling, medical services connected with surgical therapies, including vasectomy and tubal ligation.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives.
- office visits, tests and counseling for Family Planning services.
- charges made for Routine Preventive Care, not to exceed the maximum shown in the Schedule. Routine Preventive Care means health care assessments, wellness visits and any related services, including immunizations (except for those listed under "Exclusions").
- charges made for acupuncture (excluding acupressure) – must be performed by a Licensed Practitioner and medically necessary for the treatment of:
  - nausea and vomiting associated with pregnancy or chemotherapy
  - post-operative nausea or vomiting
  - post-operative dental pain if the dental treatment itself is covered under the medical plan
  - painful conditions caused by headache, low back pain, neck pain or knee pain

  Note: acupuncture is not covered for any other indications because it is considered as not medically necessary and/or experimental, investigational or unproven treatment for such conditions.
- charges made for wigs for hair loss caused by reactions from chemotherapy, radiation or multiple sclerosis. (subject to the limits described under Wigs in the Schedule of Benefits)
- orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone can not correct, provided:
  - the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
  - the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease or;
  - the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.

Clinical Trials

- charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:
- the cancer clinical trial is listed on the NIH web site www.clinicaltrials.gov as being sponsored by the federal government;
- the trial investigates a treatment for terminal cancer and: (1) the person has failed standard therapies for the disease; (2) cannot tolerate standard therapies for the disease; or (3) no effective non-experimental treatment for the disease exists;
- the person meets all inclusion criteria for the clinical trial and is not treated "off-protocol";
- the trial is approved by the Institutional Review Board of the institution administering the treatment; and
- coverage will not be extended to clinical trials conducted at non-participating facilities if a person is eligible to participate in a covered clinical trial from a Participating Provider.

Routine patient services do not include, and reimbursement will not be provided for:

- the investigational service or supply itself;
- services or supplies listed herein as Exclusions;
- services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);

- services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

Genetic Testing

- charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:
  - a person has symptoms or signs of a genetically-linked inheritable disease;
  - it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
  - the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.
- pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.
- genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per contract year for both pre- and post-genetic testing.

Nutritional Evaluation

- charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

Internal Prosthetic/Medical Appliances

- charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for non-functional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

Home Health Services

- charges made for Home Health Services when you: (a) require skilled care; (b) are unable to obtain the required care as an ambulatory outpatient; and (c) do not require confinement in a Hospital or Other Health Care Facility.

  Home Health Services are provided only if CG has determined that the home is a medically appropriate setting.

  If you are a minor or an adult who is dependent upon others for non-skilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your non-skilled care and/or custodial services needs.

  Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. Home Health Services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum shown in The Schedule.

Hospice Care Services

- charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for Bed and Board and Services and Supplies
  - by a Hospice Facility for services provided on an outpatient basis;
  - by a Physician for professional services;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
  - for pain relief treatment, including drugs, medicines and medical supplies;
  - charges made by any Other Health Care Facility for:
    - part-time or intermittent nursing care by or under the supervision of a Nurse;
    - part-time or intermittent services of an Other Health Care Professional;
    - physical, occupational and speech therapy;
    - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under

the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living;

Mental Health and Substance Abuse Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Abuse.

- **Inpatient Mental Health Services**

  Services that are provided by a Hospital while you or your Dependent is confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization and Mental Health Residential Treatment Services.

  Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of sub-acute Mental Health conditions.

  Mental Health Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; (b) provides a sub-acute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.
  A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

- **Outpatient Mental Health Services**

  Services of providers who are qualified to treat Mental Health conditions when such treatment is provided on an outpatient basis (i.e. while you or your Dependent is not confined in a Hospital) through an individual, group or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions which interfere with daily functioning such as : anxiety or depression; emotional adjustment or concerns related to chronic conditions (such as psychosis or depression); emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

  A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy during a day.

- **Inpatient Substance Abuse Rehabilitation Services**

  Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Partial Hospitalization sessions and Residential Treatment services.

  Substance Abuse Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of sub-acute Substance Abuse conditions.

  Substance Abuse Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; (b) provides a sub-acute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

  A person is considered confined in a Substance Abuse

Residential Treatment Center when she/he is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

- **Outpatient Substance Abuse Rehabilitation Services**

  Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Abuse Intensive Outpatient Therapy Program.

  A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy during a day.

- **Substance Abuse Detoxification Services**

  Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. CG will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

- **Exclusions**

  The following are specifically excluded from Mental Health and Substance Abuse Services:

  - Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
  - Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
  - Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
  - Counseling for activities of an educational nature.
  - Counseling for borderline intellectual functioning.
  - Counseling for occupational problems.
  - Counseling related to consciousness raising.
  - Vocational or religious counseling.
  - I.Q. testing.
  - Custodial care, including but not limited to geriatric day care.
  - Psychological testing on children requested by or for a school system.
  - Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

Durable Medical Equipment

- charges made for rental or purchase (if appropriate) of Durable Medical Equipment that is ordered or prescribed by a Physician for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use outside a hospital or other health care facility; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

- **Bed-related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including non-power mattresses, custom mattresses and posturepedic mattresses.
- **Bath-related Items:** bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto-tilt chairs.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers, air purifiers and electrostatic machines.
- **Blood/Injection Related Items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors.
- **Other Equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural

drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

External Prosthetic Appliances and Devices

Charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect.

External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splints.

- **Prostheses/Prosthetic Appliances and Devices**

  Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

  - basic limb prostheses;
  - terminal devices such as hands or hooks; and
  - speech prostheses.

- **Orthoses and Orthotic Devices**

  Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

  - Non-foot orthoses – only the following non-foot orthoses are covered:
    - rigid and semi-rigid custom fabricated orthoses,
    - semi-rigid prefabricated and flexible orthoses, and
    - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
  - Custom foot orthoses – custom foot orthoses are only covered as follows:
    - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
    - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
    - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
    - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

  The following are specifically excluded orthoses and orthotic devices:

  - prefabricated foot orthoses;
  - cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations of the External Prosthetic Appliances and Devices benefit;
  - orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
  - orthoses primarily used for cosmetic rather than functional reasons; and
  - orthoses primarily for improved athletic performance or sports participation.

- **Braces**

  A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

  (Copes scoliosis braces are specifically excluded. Coverage of all other braces is subject to Medical Necessity.)

- **Splints**

  A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

- **Replacement of External Prosthetic Appliances/Devices**

  Coverage for replacement of external prosthetic appliances and devices is limited to the following:

  - replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
  - replacement when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
  - replacement due to a surgical alteration or revision of the site.
  - replacement frequency is limited as follows:
    - no more than once every 24 months for persons 19 years of age and older and
    - no more than once every 12 months for persons 18

years of age and under.

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- myoelectric prostheses peripheral nerve stimulators.

Infertility Services

- charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: infertility drugs which are administered or provided by a Physician or a pharmacy; approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; artificial insemination; diagnostic evaluations; gamete intra-fallopian transfer (GIFT); in vitro fertilization (IVF); zygote intra-fallopian transfer (ZIFT); and the services of an embryologist.

Infertility is defined as the inability of opposite sex partners to achieve conception after one year of unprotected intercourse; or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period. This benefit includes diagnosis and treatment of both male and female infertility.

However, the following are specifically excluded infertility services:

- donor charges and services;
- cryopreservation of donor sperm and eggs; and
- any experimental, investigational or unproven infertility procedures or therapies.

Short-Term Rehabilitative Therapy

Short-term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitations apply to Short-term Rehabilitative Therapy:

- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or Sickness.
- To be covered all therapy services must be restorative in nature. Restorative Therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of Injury or Sickness. Restorative Therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the Injury or Sickness.

Short-term Rehabilitative Therapy services that are not covered include but are not limited to:

- sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury; and
- maintenance or preventive treatment consisting of routine, long-term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status; and
- services which are custodial, training, educational or developmental in nature.

Services that are provided by a chiropractic Physician are not covered under the Short Term Rehabilitation benefit.

Chiropractic Care Services

Charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

The following limitation applies to Chiropractic Care Services:

- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness;
- To be covered all therapy services must be restorative in nature. Restorative Therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of Injury or Sickness. Restorative Therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the Injury or Sickness.

Chiropractic Care services that are not covered include but are not limited to:

- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;

CIGNA HealthCare

- maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;
- services which are custodial, training, educational or developmental in nature; and
- vitamin therapy.

Transplant Services

- charges made for human organ and tissue transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations.

  Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel, liver or multiple viscera.

  Transplant services are payable at the In-Network level when available at and received from CIGNA LIFESOURCE Transplant Network® Facilities.

  Transplant services that are available at CIGNA LIFESOURCE Transplant Network® facilities but received from any other facility are payable at the Out-of-Network level (even if the provider who performs such service, or the facility in which services are rendered, is in the OAP network).

  Transplant services not available at CIGNA LIFESOURCE Transplant Network® Facilities but received at an OAP network facility are payable at the In-Network level.

  All Transplant services received from non-Participating Providers are payable at the Out-of-Network level.

  Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant Travel Services

Charges made for reasonable travel expenses incurred by you in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available to you only if you are the recipient of a pre-approved organ/tissue transplant from a designated CIGNA LIFESOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); lodging while at, or traveling to and from the transplant site; and food while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver. The following are specifically excluded travel expenses:

- travel costs incurred due to travel within 60 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.
- these benefits are only available when the covered person is the recipient of an organ transplant. No benefits are available when the covered person is a donor.

Breast Reconstruction and Breast Prostheses

Charges made for reconstructive surgery following a mastectomy; benefits include: (a) surgical services for reconstruction of the breast on which surgery was performed; (b) surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance; (c) postoperative breast prostheses; and (d) mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery or Therapy

Charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: (a) the surgery or therapy restores or improves function; (b) reconstruction is required as a result of Medically

Necessary, non-cosmetic surgery; or (c) the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

Exclusions, Expenses Not Covered and General Limitations

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following charges and/or services is specifically excluded from this Plan:

- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- for or in connection with an Injury or Sickness which is due to war, declared or undeclared.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this Plan.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to:
  - not demonstrate through existing peer-reviewed, evidence-based, scientific literature being safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - not be approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use (note: FDA approval does not guarantee coverage);
  - be the subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the "Clinical Trials" section of this plan; or
  - be the subject of a clinical trial, except as provided in the "Clinical Trials" section of this plan.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- regardless of clinical indication, charges for rhinoplasty; blepharoplasty; acupressure; dance therapy; movement therapy; applied kinesiology; rolfing; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- surgical or non-surgical treatment of TMJ dysfunction.
- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth (natural teeth that are free of active dental decay, have at least 50% bony support and are functional in the arch); (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; (c) charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery
- for medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung, and Blood Institute (NHLBI) guideline is covered only at approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35-39 with comorbidities. The following are specifically excluded:
  - medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and
  - weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- unless otherwise covered in this Plan, charges for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Participating Physician and listed as covered in this plan.

- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- non-medical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long-term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" section of this plan.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs (with the exception of hair loss caused by cancer treatment or multiple sclerosis).
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- aids or devices that assist with non-verbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- medical benefits for eyeglasses, contact lenses or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.
- charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
- all non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan (infertility drugs are covered).
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, e-mail, and Internet consultations, and telemedicine.
- massage therapy.
- for charges which would not have been made if the person had no coverage.
- to the extent that they are more than Maximum Reimbursable Charges.

- expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.
- charges made by any covered provider who is an immediate member of your family or your Dependent's family.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Coverage under this Plan plus another Plan will not guarantee 100% total reimbursement. Payment by all plans will not exceed what would have been paid by this Plan alone.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical care or treatment:

(1) Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public nor is individually underwritten including closed panel coverage.

(2) Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.

(3) Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical benefits primarily in the form of services through a panel of employed or contracted providers, and which limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines its benefits, and may reduce them, after taking into consideration the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to a participant.

Note: total reimbursement from the Primary Plan and Secondary Plan will not exceed the more generous Plan's total obligation for allowable expenses. (This means that if this medical plan is determined to be the Secondary Plan, and the Primary Plan pays benefits that are equal to or greater than those available under this plan, then there will be no payment under this plan.) Benefits payable from all other Plans include all covered expenses, whether a claim has been submitted for them.

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service if rendered under similar or comparable circumstances by other health care providers located within the immediate geographic area where the health care service was delivered.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

(1) The Plan that covers a person as an enrollee or an employee shall be the Primary Plan and the Plan that covers that person as a Dependent shall be the Secondary Plan;

(2) For a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year;

(3) For the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:

(a) first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;

(b) then, the Plan of the parent with custody of the child;

(c) then, the Plan of the spouse of the parent with custody of the child;

(d) then, the Plan of the non-custodial parent of the child,

and

(e) finally, the Plan of the spouse of the parent not having custody of the child.

(4) The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(5) The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(6) If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, the benefits that would be payable under this Plan in the absence of Coordination will be reduced by the benefits payable under all other Plans for the expense covered under this Plan.

When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service rendered will be considered both an expense incurred and a benefit payable.

Recovery of Excess Benefits

If CG pays charges for services and supplies that should have been paid by the Primary Plan, CG will have the right to recover such payments.

CG will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments were made by any insurance company, healthcare plan or other organization. Upon CG's request, you may be required to execute and deliver to them such instruments and documents as CG determines to be necessary to secure their right of recovery.

Right to Receive and Release Information

CG, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Medicare Eligibles

CG will pay as the Secondary Plan as permitted by the Social Security Act of 1965, as amended, for the following:

a) a former Employee who is eligible for Medicare and whose coverage is continued for any reason as provided in this Plan;

b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose coverage is continued for any reason as provided in this Plan;

c) an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;

d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;

e) an Employee or a Dependent of an Employee whose Employer has fewer than 20 Employees, if that person is eligible for Medicare due to age;

f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

CG will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.

CIGNA HealthCare

- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.
- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

This reduction will not apply to any Employee and his Dependent or any former Employee and his Dependent unless he is listed under (a) through (f) above.

Right of Reimbursement

The Policy does not cover:

1. Expenses for which another party may be responsible as a result of liability for causing or contributing to the injury or illness of you or your Dependent(s).
2. Expenses to the extent they are covered under the terms of any automobile medical, automobile no fault, uninsured or underinsured motorist, workers' compensation, government insurance, other than Medicaid, or similar type of insurance or coverage when insurance coverage provides benefits on behalf of you or your Dependent(s).

If you or a Dependent incur health care Expenses as described in (1) and (2) above, Connecticut General shall automatically have a lien upon the proceeds of any recovery by you or your Dependent(s) from such party to the extent of any benefits provided to you or your Dependent(s) by the Policy. You or your Dependent(s) or their representative shall execute such documents as may be required to secure Connecticut General's rights. Connecticut General shall be reimbursed the lesser of:

the amount actually paid by CG [or the Health Plan] under the Policy; or

an amount actually received from the third party;

at the time that the third party's liability is determined and satisfied; whether by settlement, judgment, arbitration or otherwise.

Payment of Benefits

To Whom Payable

All Medical Benefits are payable to you. However, at the option of CG, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

Medical Benefits are not assignable unless agreed to by CG. CG may, at its option, make payment to you for the cost of any Covered Expenses received by you or your Dependent from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependent is responsible for reimbursing the Provider. If any person to whom benefits are payable is a minor or, in the opinion of CG, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, CG may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release CG from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by CG when it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by CG, CG will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

Calculation of Covered Expenses

CG, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology.
- the methodologies as reported by generally recognized professionals or publications.

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

1. Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
2. Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Subrogation/Right of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

1. Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
2. Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

Lien of the Plan

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

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Payment of Benefits

To Whom Payable

All Medical Benefits are payable to you. However, at the option of CG, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

Medical Benefits are not assignable unless agreed to by CG. CG may, at its option, make payment to you for the cost of any Covered Expenses received by you or your Dependent from a Non-Participating Provider even if benefits have been

assigned. When benefits are paid to you or your Dependent, you or your Dependent is responsible for reimbursing the Provider. If any person to whom benefits are payable is a minor or, in the opinion of CG, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, CG may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release CG from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by CG when it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by CG, CG will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

Calculation of Covered Expenses

CG, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology.
- the methodologies as reported by generally recognized professionals or publications.

Termination of Coverage

Termination of Coverage - Employees

Your coverage will cease on the last day of the month in which:

- you cease to qualify for the coverage due to a reduction in work hours or change to an ineligible employee status.
- you discontinue making any required contribution for the coverage.
- the Plan is canceled.
- your Active Service ends except as described below.

Leave of Absence

If your Active Service ends due to an approved leave of absence, you may continue your coverage for up to three months. For the first month of your personal leave, you are required to submit to your Employer the contribution amount that would have been deducted from your paycheck as payment to continue your coverage. For subsequent months, you are responsible for paying the full cost of coverage. Your coverage will not be continued for more than 90 days past the date your Active Service ends.

Family and Medical Leave

If your active service ends due to an approved Family and Medical leave, you may continue your health coverage for up to 12 weeks. During this period you are required to submit to your Employer the contribution amount that would have been deducted from your paycheck as payment to continue your coverage. However, if you choose not to return to Active Service at the end of your leave, your Employer may require you to pay for the full cost of coverage.

Disability - Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your coverage may continue for up to one year after your date of disability unless, in certain circumstances, you are eligible to retire.

Termination of Coverage - Dependents

Coverage for all of your Dependents will cease on the last day of the month in which:

- your coverage ceases.
- you discontinue making any required contribution for the coverage.
- the Plan is canceled.

The coverage for any one of your Dependents will cease on the last day of the month in which the Dependent no longer qualifies as a Dependent.

If you die while as an employee in Active Service, coverage for your Dependents may continue under COBRArules for up to 36 months. Your Employer pays the full cost of continuation coverage for the first 24 months. However, your employer will cease to pay for continuation of coverage if within the first 24 months: your surviving spouse remarries; or your Dependents become eligible for other group health coverage; or, your Dependents become entitled to Medicare benefits.

Note: You and/or your Dependents may have certain rights to continue coverage under COBRA following its termination. See the "COBRA Continuation Rights" section of this booklet for more information.

Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

If your Plan utilizes a network of Providers, you will automatically and without charge, receive a separate listing of Participating Providers.

You may also have access to a list of Providers who participate in the network by visiting http://provider.healthcare.cigna.com/EsteeLauder.html; www.cigna.com; mycigna.com; or by calling the toll-free telephone number on your ID card.

Your Participating Provider network consists of a group of local medical practitioners, including Hospitals, of varied specialties as well as general practice, that are employed by or contracted with CIGNA HealthCare through the Open Access Plus network.

Qualified Medical Child Support Order (QMCSO)

A. Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child and yourself, if you are not already enrolled, within 31 days of the QMCSO being issued.

B. Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

1. the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
2. the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
4. the order states the period to which it applies; and
5. if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

C. Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

FDRL2 V1

Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

If you or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible

CIGNA HealthCare

Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option offered by the Employer for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option. The special enrollment events include:

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage. Dependent children who were already Dependents of the Employee but not currently enrolled in the Plan are not entitled to special enrollment.
- **Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Employee;
  - termination of employment;
  - reduction in work hours to below the minimum required for eligibility;
  - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
  - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
  - the other plan no longer offers any benefits to a class of similarly situated individuals.
- **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: (a) due to failure of the employer or other responsible entity to remit premiums on a timely basis; (b) when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or (c) when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.

FDRL3 V4

- **Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately

on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

Individuals who enroll in the Plan due to a special enrollment event will not be considered Late Entrants. Any Pre-existing Condition limitation will be applied upon enrollment, reduced by prior Creditable Coverage, but will not be extended as for a Late Entrant.

Domestic Partners and their children (if not legal children of the Employee) are not eligible for special enrollment.

FDRL4 V3

Coverage of Students on Medically Necessary Leave of Absence

If your Dependent child is covered by this plan as a student, as defined in the Definition of Dependent, coverage will remain active for that child if the child is on a medically necessary leave of absence from a postsecondary educational institution (such as a college, university or trade school.)

Coverage will terminate on the earlier of:

a) The date that is one year after the first day of the medically necessary leave of absence; or

b) The date on which coverage would otherwise terminate under the terms of the plan.

The child must be a Dependent under the terms of the plan and must have been enrolled in the plan on the basis of being a student at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence.

The plan must receive written certification from the treating physician that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

A "medically necessary leave of absence" is a leave of absence from a postsecondary educational institution, or any other change in enrollment of the child at the institution that: (1) starts while the child is suffering from a serious illness or condition; (2) is medically necessary; and (3) causes the child to lose student status under the terms of the plan.

FDRL76

Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exception for Newborns" section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

FDRL6

Federal Tax Implications for Dependent Coverage

Premium payments for Dependent health insurance are usually exempt from federal income tax. Generally, if you can claim an individual as a Dependent for purposes of federal income tax, then the premium for that Dependent's health insurance coverage will not be taxable to you as income. However, in the rare instance that you cover an individual under your health insurance who does not meet the federal definition of a Dependent, the premium may be taxable to you as income. If you have questions concerning your specific situation, you should consult your own tax consultant or attorney.

FDRL7

Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under a federal law known as the "Newborns' and Mothers' Health Protection Act": restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

FDRL8

Women's Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.

FDRL51

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

FDRL75

Obtaining a Certificate of Creditable Coverage Under This Plan

Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will be mailed to each terminating individual at the last address on file. You or your dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. You may need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, contact the Plan Administrator or call the toll-free customer service number on the back of your ID card.

FDRL50

Requirements of Medical Leave Act of 1993 (as amended) (FMLA)

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, as amended, where applicable:

A.Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

B. Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre-existing Condition limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993, as amended.

FDRL74

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

A. Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

You may continue benefits by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

B. Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if (a) you gave your Employer advance written or verbal notice of your military service leave, and (b) the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a Pre-Existing Condition Limitation (PCL) or waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

Any 63-day break in coverage rule regarding credit for time accrued toward a PCL waiting period will be waived.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

FDRL58

Claim Determination Procedures Under ERISA

The following complies with federal law effective July 1, 2002. Provisions of the laws of your state may supersede.

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical Necessity determinations are made on either a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice medical necessity determination." The Certificate describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care provider) must request Medical Necessity determinations according to the procedures described below, in the Certificate, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not Medically Necessary, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider's network participation documents, and in the determination notices.

Preservice Medical Necessity Determinations

When you or your representative request a required Medical Necessity determination prior to care, CG will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond CG's control, CG will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to CG within 45 days after receiving the notice. The determination period will be suspended on the date CG sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would (a) seriously jeopardize your life or health, your ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, CG will make the preservice determination on an expedited basis. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited determination is necessary. CG will notify you or your representative of an expedited determination within 72 hours after receiving the request.

FDRL65

However, if necessary information is missing from the request, CG will notify you or your representative within 24 hours after receiving the request to specify what information is

CIGNA HealthCare

needed. You or your representative must provide the specified information to CG within 48 hours after receiving the notice. CG will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If you or your representative fails to follow CG's procedures for requesting a required preservice medical necessity determination, CG will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

Concurrent Medical Necessity Determinations

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent Medical Necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, CG will notify you or your representative of the determination within 24 hours after receiving the request.

Postservice Medical Necessity Determinations

When you or your representative requests a Medical Necessity determination after services have been rendered, CG will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CG's control CG will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to CG within 45 days after receiving the notice. The determination period will be suspended on the date CG sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

FDRL42

Postservice Claim Determinations

When you or your representative requests payment for services which have been rendered, CG will notify you of the claim payment determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CG's control, CG will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date CG sends such a notice of missing information, and resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and (6) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

FDRL36

When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you," "your," or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

"Physician Reviewers" are licensed Physicians depending on the care, service or treatment under review.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start With Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you may call the toll-free number on your Benefit Identification card, explanation of benefits, or claim form and

CIGNA HealthCare

explain your concern to one of our Member Services representatives. You may also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Appeals Procedure

CG has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to CG within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask CG to register your appeal by telephone. Call or write us at the toll-free number on your Benefit Identification card, explanation of benefits, or claim form.

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination, and within 30 calendar days after we received an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CG will respond orally with a decision within 72 hours, followed up in writing.

FDRL37

Level-Two Appeal

If you are dissatisfied with our level-one appeal decision, you may request a second review. To initiate a level-two appeal, follow the same process required for a level-one appeal.

Most requests for a second review will be conducted by the Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness the Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by CG's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For level-two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations the Committee review will be completed within 15 calendar days and for post service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within 5 business days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician, would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CG will respond orally with a decision within 72 hours, followed up in writing.

Independent Review Procedure

If you are not fully satisfied with the decision of CG's level-two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by CIGNA HealthCare, or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this Independent Review Process. CG will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, the reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by CG. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

FDRL63

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of CG's level-two appeal review denial. CG will then forward the file to the Independent Review organization. The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your medical condition, as determined by CG's Physician reviewer, the review shall be completed within 3 days. The Independent Review Program is a voluntary program arranged by CG.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant information is any document, record or other information which: (a) was relied upon in making the benefit determination; (b) was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against CG until you have completed the Level-One and Level-Two appeal processes. If your appeal is expedited, there is no need to complete the Level-Two process prior to bringing legal action.

FDRL40

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct, or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

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Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, same sex spouses, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

FDRL67

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

1. SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
2. A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

FDRL21

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with CIGNA;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: (a) the end of the applicable maximum period; (b) the date the pre-existing condition provision is no longer applicable; or (c) the occurrence of an event described in one of the first three bullets above; or

CIGNA HealthCare

- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Moving Out of Employer's Service Area or Elimination of a Service Area

If you and/or your Dependents move out of the Employer's service area or the Employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to out-of-network coverage only. In-network coverage is not available outside of the Employer's service area. If the Employer offers another benefit option through CIGNA or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

FDRL22 V1

Employer's Notification Requirements

Your Employer is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  (a) if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  (b) if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  (c) in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

FDRL23

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member. For example:

If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

CIGNA HealthCare

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

FDRL24 V2

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation;
- Your child ceases to qualify as a Dependent under the Plan; or
- The occurrence of a secondary qualifying event as discussed under "Secondary Qualifying Events" above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled "Disability Extension" for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer's Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under "Termination of COBRA Continuation" above.

FDRL25 V1

Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

CIGNA HealthCare

In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed under "Termination of COBRA Continuation" above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify the Plan Administrator immediately.

Conversion Available Following Continuation

If your or your Dependents' COBRA continuation ends due to the expiration of the maximum 18-, 29- or 36-month period, whichever applies, you and/or your Dependents may be entitled to convert to the coverage in accordance with the Medical Conversion benefit then available to Employees and the Dependents. Please refer to the section titled "Conversion Privilege" for more information.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

FDRL26

ERISA Required Information

Participating Companies

As of June 1, 2007, the following companies participate in The Estee Lauder Companies Inc. Health Care Program:

Aveda Corp.
Aveda Experience Centers Inc.
Aveda Institute Inc
Aveda Institute Washington, DC LLC
Aveda Services Inc.
BeautyBank Brands Inc.
BeautyBank Inc
Clinique Services LLC
Darphin LLC
ELC Beauty LLC
ELC Management LLC
Estee Lauder Travel Retail Services Inc.
M.A.C. Cosmetics Inc.
Make-Up Art Cosmetics Inc.
Northtec LLC
RSL Management Corp.
Whitman Packaging Corp.

Plan Identification Number

503

Plan Sponsor and Administrator

The name, address, ZIP code and business telephone number of the Plan Sponsor and Administrator is:

The Estee Lauder Companies Inc.
767 Fifth Avenue
New York, NY 10153
Attention: Human Resources Department
(212)572-4200

Agent for Service of Legal Process

The name, address and ZIP code of the person designated as agent for the service of legal process is:

Employer named above

Claims Administrator

The CG Claim Office responsible for the processing of claims (including the appeal of any claim denials) under this Plan is:

CIGNA Corporation

PO Box 5200

Scranton, PA 18505-5200

Plan Type

The Plan is a welfare benefit plan

Employer Identification Number

The Employer Identification Number assigned by the Internal Revenue Service to The Estée Lauder Companies Inc. is 11-2408943.

"Stop Loss" Insurance

The medical plans have "stop loss" insurance provided by:
IOA Re
630 W. Germantown Pike
PO Box 975
Plymouth Meeting, PA 19462-0975

Plan Year

The Plan's fiscal year is from January 1-December 31.

Plan Funding

Benefits provided by the Plan are funded by Employee and Employer contributions. The Estee Lauder Companies Inc. is responsible for paying Plan benefits.

CIGNA HealthCare

Medical Examination

The Claims Administrator, at its own expense, has the right to require a medical examination of any individual for whom a claim is pending when it is reasonably required.

Right to Recover Excess Payments

The Plan Administrator has the right to recover payments made from the Plan that exceed the amounts that should have been paid.

Third Party Liability

If you or a Dependent suffer an illness or injury involving a third party who is liable for any resulting medical expenses, you will be required to assign to the Plan any amounts you receive from the third party , up to the amounts paid by the Plan for expenses related to such illness or injury.

The Plan and/or its designated agent shall determine the standards, procedures and practices used to pursue recovery of such duplicate payments, including the use of litigation, as necessary.

Discretionary Authority

The Plan Administrator delegates to CG the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to CG the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. The procedure by which benefits may be changed or terminated, by the which the eligibility of classes of employees may be changed or terminated, or by which part of all of the Plan may be terminated, is contained in the Employer's Plan Document, which is available for inspection and copying from the Plan Administrator designated by the Employer. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates.

Your coverage under the Plan will end on the earliest of the following dates:

- the last day of the calendar month in which you leave Active Service;
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

Statement of Rights

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your federal continuation coverage rights.
- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health

plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If you claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

If you have questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

CG will provide administrative services of the following nature: Claim Administration; Cost Containment; Financial; Banking and Billing Administration.

Benefits provided under this Plan are self-insured by the Employer.

This document is issued by:

Connecticut General Life Insurance Company
900 Cottage Grove Road
Hartford, CT 06152

CIGNA HealthCare

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business, at some location to which you are required to travel for your Employer's business or at any other location agreed upon by your employer.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Charges

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with CG for a different amount.

Chiropractic Care

The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

Custodial Services

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking, (b) grooming, (c) bathing, (d) dressing, (e) getting in or out of bed, (f) toileting, (g) eating, (h) preparing foods, or (i) taking medications that can be self administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

Dependent

Dependents are:

- your lawful spouse;
- your same sex Domestic Partner; and
- any unmarried natural child of yours who:
  - has not reached the end of the calendar year in which they attain age 25;
  - is 25 or more years old, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap that commenced prior to age 25. Newly eligible employees may enroll an incapacitated handicapped child who is over age 25 provided the disability began prior to that age and the child has been continuously covered as a Dependent of the employee under another health benefit plan since age 25. Proof of the child's condition and dependence must be submitted to CG within 31 days after you first become eligible for medical plan coverage or, if already enrolled, the date your child ceases to qualify as a Dependent, as described above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.
  - depends on you for financial support (except in the case of a "Qualified Medical Support Order").
- the term child also includes the following individuals who meet the above age and dependency criteria :
  - legally adopted children (eligible for coverage from the start of any waiting period before the adoption becomes final);
  - stepchildren who live with you;
  - children of your Domestic Partner who live with you;
  - children for whom you have been appointed legal guardian and who live with you.

Benefits for a Dependent child will continue until the last day of the calendar year in which the limiting age is reached (age 25), unless he or she is handicapped, as described above.

Anyone who is eligible as an Employee will not be considered as a Dependent (i.e. no one can be covered as both an Employee and a Dependent). So, if both you and your spouse work for The Estee Lauder Companies, "double coverage" is not permitted.

No one may be considered as a Dependent of more than one Employee.

CIGNA HealthCare

Upon request, you may be required to submit proof of the eligible status of any Dependents enrolled for Health Care Program coverage.

Domestic Partner

A Domestic Partner is defined as a person of the same sex who:

- shares your permanent residence;
- has resided with you for no less than one year;
- is no less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by CG to be sufficient to establish financial interdependency under the circumstances of your particular case;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, and submitted to your Employer, a notarized "Statement of Domestic Partnership", which can be made available to CG upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

The section of this booklet entitled "COBRA Continuation Rights Under Federal Law" will not apply to your Domestic Partner and his or her Dependents.

Emergency Services

Emergency services are medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily Injury or serious Sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the UB92 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

Employee

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 30 hours a week for the Employer.

Employer

The term Employer means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf CG is providing claim administration services.

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

Free-Standing Surgical Facility

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

Health Care Program

In addition to The Custom Care and Comprehensive Plus Medical Plans, the Health Care Program includes The Medical Plan, The Prescription Drug Plan and The Dental Assistance Plan, which are described in separate booklets. If you elect to

enroll in one of the Medical Plans, you and your covered Dependents (if any) will automatically be covered by The Prescription Drug and Dental Assistance Plans.

Healthy Babies Program

A special program designed to help you have a healthy pregnancy and your baby a healthy start in life. The program offers around-the clock access to a toll-free information line staffed by experienced registered nurses who can answer any questions you may have. It also makes available free educational materials about pregnancy and babies.

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

Hospice Care Services

The term Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by CG; and
- fulfills any licensing requirements of the state or locality in which it operates.

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: (a) specializes in treatment of Mental Health and Substance Abuse or other related illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program;
- receiving treatment for Mental Health and Substance Abuse Services in a Mental Health or Substance Abuse Residential Treatment Center.

Injury

The term Injury means an accidental bodily injury.

In-Store Employee

The term In-Store Employee means a person who is paid weekly and works in a facility whose primary purpose is to make sales or provide services to the public.

Maintenance Treatment

The term Maintenance Treatment means:

- treatment rendered to keep or maintain the patient's current status.

Maximum Reimbursable Charge

The Maximum Reimbursable Charge is the lesser of:

1. the provider's normal charge for a similar service or supply; or
2. the policyholder-selected percentile of all charges made by providers of such service or supply in the geographic area where it is received.

To determine if a charge exceeds the Maximum Reimbursable Charge, the nature and severity of the Injury or Sickness may be considered.

CG uses the Ingenix Prevailing Health Care System database

to determine the charges made by providers in an area. The database is updated semiannually.

The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.

Additional information about the Maximum Reimbursable Charge is available upon request.

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medically Necessary/Medical Necessity

Medically Necessary Covered Services and Supplies are those determined by CG's Medical Director to be:

- required to diagnose or treat an illness, injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, CG's Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Necessary Services and Supplies

The term Necessary Services and Supplies includes:

- any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement;
- any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and
- any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

Other Health Care Facility

The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and sub-acute facilities.

Other Health Professional

The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses.

Participating Provider

The term Participating Provider means a hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with CIGNA to provide covered services with regard to a particular plan under which the participant is covered.

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this Plan when performed by a Physician.

Preventive Treatment

The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

Primary Care Physician (PCP)

The term Primary Care Physician means a Physician: (a) who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and (b) who has been selected by you, as authorized by the Provider Organization, to provide or arrange for medical care for you or

any of your insured Dependents.

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this Plan when performed by a Psychologist.

Review Organization

The term Review Organization refers to an affiliate of CG or another entity to which CG has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

Sickness – For Medical Coverage

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

Urgent Care

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by CG, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.